

# Rodney Hornbake MD, PC

## REGISTRATION FORM

(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Select One)	
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Single	<input type="checkbox"/> Mar
					<input type="checkbox"/> Div	<input type="checkbox"/> Sep
					<input type="checkbox"/> Wid	

Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
--	----------------------------------	---------------	------------	-----	--

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )
----------------	------	-------	----------	-----------------	-----------------------

P.O. Box	City	State	ZIP Code
----------	------	-------	----------

Occupation	Employer	Employer Phone No. ( )
------------	----------	---------------------------

Chose Doctor because recommended by (Please check one box)  Dr. \_\_\_\_\_  Insurance Plan  Hospital

Family  Friend  Close to Home/Work  Yellow Pages  Other \_\_\_\_\_

Name of Spouse (if applicable)

### INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
-----------------------------	-------------------	------------------------	----------------

Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No	( )
--------------------------------	--	-----

Occupation	Employer	Employer Address	Employer Phone No. ( )
------------	----------	------------------	---------------------------

Is this patient covered by insurance?  Yes  No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
-------------------	---------------------	-------------------	---------	----------	------------------

Patient's Relationship to Subscriber  Self  Spouse  Child  Other \_\_\_\_\_

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
---	-------------------	---------	----------

Patient's Relationship to Subscriber  Self  Spouse  Child  Other \_\_\_\_\_

### IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
---	-------------------------	-----------------------	-----------------------

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr Hornbake or insurance company to release any information required to process my claims.

X \_\_\_\_\_  
 PATIENT/GUARDIAN SIGNATURE DATE